STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155718	A. BUILDING _____ B. WING _____	C 02/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY NORTHVIEW CARE CENTER	1235 W CROSS ST ANDERSON, IN 46011

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaint IN00123563.

Complaint IN00123563 substantiated, no deficiencies related to the allegations are cited.

Survey dates: February 6 ,7, 2013

Facility number: 000562
Provider number:155718
AIM number: 100267150

Surveyor: Jeri Curtis, RN

Census bed type:
SNF: 3
NF: 39
SNF/NF: 33
Residential: 23
Total: 98

Census payor type:
Medicare: 23
Medicaid: 35
Other: 40
Total: 98

Sample: 5

Community Northview Care Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint IN00123563.

Quality review completed by Debora Barth, RN.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE